Eliminating Childhood Lead Poisoning in Vermont by 2011

VT Childhood Lead Poisoning Prevention Program
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Vermont Childhood Lead Poisoning Prevention Program

Statewide Plan to Eliminate Childhood Lead Poisoning

I. INTRODUCTION

The Childhood Lead Poisoning Prevention Program (CLPPP) at the Vermont Department of Health has been providing programmatic services to the state since 1992. Together with external partners, CLPPP has focused the past year and a half on the development of a strategic plan to eliminate childhood lead poisoning in the state by 2011. This strategic working group is comprised of housing experts funded by the Office of Housing and Urban Development (HUD), Environmental Protection Agency representatives, physicians, parents, contractors, parent/child centers and advocacy groups, the Department of Social and Rehabilitative Services, and various agencies and organizations committed to the elimination of childhood lead poisoning in Vermont.

Throughout the process, CLPPP will continue to analyze surveillance and environmental databases for changes in statewide data and alter plans accordingly, with the approval of CDC.

II. AN OVERVIEW OF THE VERMONT CLPPP

A. History

The Childhood Lead Poisoning Prevention Program was initiated in the State of Vermont in 1992. The Vermont Legislature passed a comprehensive lead poisoning prevention law in 1993 that requires public education, childhood lead screening guidelines, contractor licensing, and environmental follow-up on all severely lead poisoned children. In 1996, the Vermont legislature passed V.S.A. title 18, chapter 38, section 1759 Essential Maintenance - "An Act to Prevent Lead Poisoning in Children in Rental Housing and Child Care Facilities." The law represents two years of work by the Vermont Lead Paint Hazards Commission. This commission included members from health, housing, historic preservation, banking and insurance; as well as landlords, legislators, parents, tenants, advocates and contractors. Their goal was to develop low cost, “do-it-yourself,” prevention-oriented recommendations that would allow property owners to reduce health risks related to lead paint.

Owners of rental property and child care facilities built before 1978 are required to take steps to reduce hazards and prevent children from being lead poisoned. Landlords must inspect the condition of paint on their properties and perform essential maintenance annually and then sign an affidavit stating that essential maintenance has been carried out, filing it with their insurance carrier and the Health Department. They must provide occupants with a pamphlet about lead poisoning prevention and post a notice asking people to report chipping or damaged paint. After attending a required, approved

Department of Health training program, property owners may perform the essential maintenance work on their rentals, such as installing window well inserts.

The Vermont Department of Health (VDH) originally published and implemented a statewide screening guidance plan in 1994 after passage of Vermont Annotated Statute, Health- Title 18, Chapter 38 Lead Poisoning. The guidance plan called for universal screening of all Vermont 1 -year-old children. At that time the VDH CLPPP worked closely with the Vermont Chapter of the Academy of American Pediatrics (AAP) and the Vermont Department of Health's twelve local District Offices to establish procedures to assure that children of highest risk are screened for lead exposure. These procedures included lead-screening clinics for families enrolled in the Supplemental Food Program for Women, Infants, and Children (WIC).

In 2000, the Vermont Department of Health's Commissioner of Health, Dr. Jan K. Carney published and distributed a revised lead-screening plan to include screening 2-year-old children as well as 1-year-old children. The revision was necessary after the Lead Screening Advisory Committee (LSAC) met in 1999 to review the screening data and Vermont trends in elevated blood lead levels. The CDC had published its screening guidelines (1997) to assist the Vermont LSAC members in deciding on universal or targeted screening plans. Based on the factors in the CDC guidance document, universal screening (with targeted questioning for 2 year olds including pre-1978 housing, daycare, or Medicaid status) was still necessary due to the age of housing stock that exceeds twenty seven percent for all counties and most cities/towns.

Vermont's definition of severely poisoned is a venous test of 20 micrograms per deciliter or greater in blood or 2 consecutive blood lead tests in the range of 15-19 inclusive (3 or more months apart) were developed early, and continue to grow stronger in efforts to eliminate lead poisoning through promoting awareness of Vermont's Lead Poisoning Prevention Law and maintenance of housing.

In Vermont, all children under age three are considered at risk for lead poisoning. Vermont CLPPP provides the full range of prevention services statewide including, but not limited to, health education and outreach, case management, environmental testing, and laboratory analysis.

The Vermont Department of Health analyzed the surveillance data and determined the highest risk metropolitan areas based on the number and percent of elevated blood lead levels (EBLL). The metropolitan areas include Burlington, Rutland, Bennington, Brattleboro, Barre, St. Johnsbury, Springfield/Bellows Falls, and White River Jct./Randolph region. For this project period, the Vermont Department of Health will focus its resources and use the Vermont Lead Screening committee to continue training healthcare practices in screening techniques used to collect blood samples in the office.

In addition to the statewide lead-screening plan, the Vermont Department of Health's twelve Local District Offices adapted the plan for use in the community served by these offices. Subsequently the Vermont Department of Health's CLPPP worked with a liaison at each office to work on the three barriers to screening that were outlined in Vermont's Lead Screening Plan: reimbursement, testing, and importance. The Vermont Department of Health, through the Maternal Health and Childcare Coalition meetings and one on one contact with staff at the practices located in the eight high risk metropolitan areas, developed objectives for the Local District Offices to educate healthcare providers about the Medicaid reimbursement policy, to train in the best practices for finger stick testing in the office, and to disseminate screening data. The Vermont Department of Health's CLPPP plays a vital role in developing tools for the Local District Offices such as; data charts, housing stock information, level of poverty, and other factors for the high rate of elevated blood lead levels in the area.

The Vermont legislators, child advocates, housing and health organizations, and the Vermont Department of Health recognized early in the process the importance of reporting all blood lead results for children less than 6 years of age (<72 months.). In Appendix B V.S.A. (Vermont Statutes Annotates), Title 18 Health, Chapter 38 Lead Poisoning, Section 1755 required all Vermont labs and all healthcare providers to report a diagnosis of lead poisoning to the Department of Health. In 1993, the Vermont Department of Health established the foundations of the blood lead surveillance data system in order to maintain test results, demographic, environmental, and case management information for all Vermont children less than 13 years of age. During this project period the Vermont program will continue to enhance its statewide surveillance system and evaluate efforts through annual and quarterly reports to CDC, community partners, legislators, healthcare providers, and other stakeholders. The surveillance system will provide the evaluation of progress in the elimination of lead poisoning in Vermont.

The Vermont Department of Health's childhood blood lead surveillance system includes core components of a surveillance system; case management and program monitoring capabilities, determining screening and elevated blood lead level rates among Medicaid eligible children, 95% rate of laboratory blood lead test results reported electronically, electronic transfer of data from laboratories, link to birth certificate data, identification of healthcare practices using portable blood lead analyzers, and data analysis and dissemination of findings. For example with case management, the Vermont blood lead surveillance system uses a property remediation and blood lead case management date to track days to remediate, time to perform inspection and time for child's blood lead follow up test to drop below 15 micrograms per deciliter. In this project period, the surveillance coordinator will assist case manager Erica Holub by running quarterly and annual reports to evaluate progress in reducing the period of time to remediate a property and to compare that evaluation to the time elapsed prior to the child's lead level falling below 10 µg/dL.

The Vermont Department of Prevention, Assistance, Transition, and Health Access's (PATH) Medicaid program has given the Vermont Department of Health access to their claims data. Since 2001, the surveillance coordinator has matched the children enrolled in Medicaid with the Vermont blood lead surveillance system to determine the percentage of 1-7 year-old children screened for lead. This process will continue for the elimination plan project period and expand to assessing the eight high-risk metropolitan areas and the rates of screening Medicaid enrolled children. Data for one and two year olds will be evaluated in annual reports.

The Vermont program receives 95% of all blood lead test results by electronic transfer. There are two laboratories that report most blood lead tests; the Vermont Department of Health's Public Health Lab and Fletcher Allen Healthcare (FAHC) Hospital Lab both located in Burlington. In this project period, the Vermont Department of Health seeks to enhance the system to include some missing demographic information from both labs. For instance, the electronic laboratory based reporting (ELR) currently includes the date of birth, child's name, healthcare providers, and test result 100 % of the time. However, demographic information such as the healthcare provider license number and address, parents name and address are often missing and collected through written reports from the hospital or healthcare provider that collected the sample. This requires staff time to enter these data fields.

For the other 5% of blood lead results that are received by the Vermont Department of Health, the CLPPP will focus attention on the out of state private labs, neighboring state CLPPP, and manufacturer of the portable hand held lead instrument to improve electronic laboratory based reporting. At this time there is an agreement between the manufacturer of the portable hand held instrument (ESA) and the Vermont Department of Health that requires notification to the physician of Vermont's reporting requirements. Essex Pediatrics located in one of the eight targeted metropolitan areas uses the instrument and has provided written reports to the Vermont Department of Health. During this project period, the Vermont program will work with Essex Pediatrics and the manufacturer to see if electronic transmission is feasible. The Vermont Department of Health will also talk with New Hampshire, Massachusetts, and New York CLPPP about the best practice to report children that are screened in their states but live in Vermont. Currently written reports are submitted between states with the goal of electronic transmission for the future. Lastly the out of state labs will be included in the discussions with neighboring states in efforts to reduce duplication of blood lead reporting.

The collaboration between the Vermont Department of Health CLPPP, WIC (Supplemental Food Program for Women, Infants, and Children) and immunization programs remains strong. The Vermont Department of Health's Local District Offices are located in the heart of the eight targeted metropolitan areas. Subsequently the staff at the Local District Offices run health clinics through WIC and immunization programs and will ask the parent if the child has received a lead screen. At the health clinics for one and

two year-olds that are enrolled in the WIC program, and for whom a blood lead test has not already been taken at the primary care provider's office, a sample of blood is drawn.

The Vermont Department of Health can now send out postcard reminders to parents of children turning 1 and 2 years of age with the coordination between the CLPPP and Vital Records program. The postcard label is initiated through the Vermont Department of Health's Vital Records database that includes all birth certificates. The Vermont Department of Health's CLPPP developed the postcard that generated with the mailing information for children turning 10 or 22 months. The postcard reminds the parent/guardian about getting a lead test for the child. The Vermont Department of Health surveillance system will continue to track in this next project period the impact of these postcards on the percentage of 1 and 2 year old children screened for lead in the metropolitan areas and across the state. Finally, the Vermont Department of Health blood lead surveillance system will guide, monitor, and evaluate CLPPP components and activities. For example, data will be used from the surveillance system for the workgroup members of the Vermont Childhood Lead Elimination Plan to review and determine actions. Quarterly review of remediation trends will be examined to improve the turnaround time of a severely lead poisoned child.

Primary prevention activities are also monitored through Vermont's blood lead surveillance system. The eight metropolitan areas of highest risk work to improve housing by education to the community on Vermont's Lead Poisoning Prevention Law. As such, the Vermont CLPPP, local District Offices, Visiting Nurses Association, Rental Property Owners Association, tenant advocacy groups, local housing authorities, and appointed city health officers work jointly to educate the community in ways to repair paint and protect children before they are poisoned.

Health Education

CLPPP funds 1.5 FTE central staff positions dedicated to health education and outreach and six .25FTEs at the local level Health Department District offices. The target populations for outreach messaging are: property owners, child care providers, parents, tenants, and health care professionals. CLPPP manages a toll free lead hotline (1-800-439-8550) and a widely used website. Numerous materials are developed both internally and through the use of media contractors. Local public access radio and television stations are amenable to working with the Lead Program and it has proven to be an effective means of information dissemination.

One CLPPP central staff health educator, Marcia Gustafson, is funded partly through a contract with the Vermont Housing and Conservation Board (VHCB), a Housing and Urban Development (HUD) funded agency. It is one way in which our strong collaboration is apparent. Marcia does home visits for families enrolled in VHCB's housing remediation program and for CLPPP. She is a certified lead inspector/risk assessor.

Children who have a blood lead level (BLL) of 10-14 µg/dL receive a phone call at their home from a health educator from CLPPP. This person will talk with the parent about the condition of the property and how they can work to lower the BLL of their child. They will also receive materials in the mail, such as nutrition and cleaning information. Children who have a BLL of 15-19 µg/dL will receive a home visit from CLPPP. Some minor environmental sampling (soil, water, and dust) helps families to understand where their "hot spots" are and how to remediate them safely. The health educator will also speak with them about nutrition and cleaning.

Case Management

Erica Holub is a licensed lead inspected and certified risk assessor and Case Manager for the Vermont CLPPP. Erica is responsible for doing home visits to families with children with EBLs of a consecutive 15-19 µg/dL or a 20+ µg/dL. On her visit, she does a full environmental investigation including, dust, water and soil samples, and XRF readings of all the interior surfaces under HUD guidelines. She spends a good deal of time with the child's primary childcare provider (i.e. parent, guardian) talking about nutrition and doing developmental counseling. She discusses ways in which the parent/guardian can keep their property lead-safe through a cleaning regime and paint/dust stabilization.

All children who fall under the category of qualifying for case management (consecutive 15-19 µg/dL or a 20+ µg/dL) automatically qualify for the Family, Infant, Toddler Program (FITP), which is a program within the Health Department. Families who are referred to FITP receive nutritional and developmental assessments and counseling until the BLL drops below 10 µg/dL. This partnership is a very exciting one. FITP counselors may do the initial visit with Erica and then take over the family's care at that point. They are trained in the developmental tools recommended by CDC and they have many nutritionists on staff.

The Family, Infant and Toddler Program of Vermont is a family-centered coordinated system of early intervention services for infants and toddlers who have a delay in their development, or a health condition which may lead to a delay in development, and their families. The Program brings together families and service providers from many aspects of the community, including public and private agencies, parent child centers, local school districts, health care practitioners, private therapists, and child care providers. Supports and services come together to meet each child's unique needs and the needs of their family in their home and community. Early intervention resources and supports might include help with obtaining and coordinating community services and supports, which may include:

- assistive technology
- a trained home visitor/child development specialist
- health services to help a child benefit from other early intervention services
- nursing
- physical and occupational therapy
- counseling/psychological and social work services

- special instruction
- transportation assistance
- medical diagnosis for evaluation & eligibility
- hearing and vision services
- nutrition
- communication
- social work

Information Systems

Data is analyized internally in the CLPPP program by the Lead Surveillance Specialist. This position is currently vacant. We're in the process of recruiting and interviewing at the time of this submission. The Lead Surveillance Specialist provides detailed statistical information that guides program activity and affords solid program evaluation. The CLPPP database is able to identify and track children with EBLs, track screening rates over time, query environmental and geographic risk factors, and track EBL trends.

The Vermont Department of Health's childhood blood lead surveillance system includes core components of a surveillance system; case management and program monitoring capabilities, determining screening and elevated blood lead level rates among Medicaid eligible children, 95% rate of laboratory blood lead test results reported electronically, electronic transfer of data from laboratories, link to birth certificate data, identification of healthcare practices using portable blood lead analyzers, and data analysis and dissemination of findings.

Statistical information is provided to CDC as requested. There are many requests for information for agencies and organizations throughout Vermont and the nation. In 2005, CLPPP looks forward to publishing a data book for distribution.

Healthy Homes Initiative

CLPPP's Healthy Homes initiative is dedicated to helping families reduce environmental hazards in the home that lead to disease and injury, primarily among young children. Grants are administered through local Emergency Medical Service (EMS) Providers statewide. It focuses on a wide range of hazards, including lead paint, poor indoor air quality, mold, pests, fire, structural defects, and injury hazards. The services of this initiative include: home assessment, and individual counseling on hazard reduction; community education and primary prevention through home shows, health fairs, and other local events.

B. *Mission Statement*

Vermont will eliminate childhood lead poisoning by 2011 through the mobilization of parents and other caregivers, public health, medical services and those involved in the renovation and painting of buildings to ensure that children do not come into contact with lead contaminated materials, and those that do are identified before poisoning occurs.

C. *Need*

Vermont is among the seven so-called 'Lead Leaders' (Governing, 1992) -- states in which a large percentage of the housing stock was built prior to 1940, with older rental housing stock in generally poor condition and presenting a high risk of lead exposure to children. With 61% of the homes in Vermont built before 1978, there is a tremendous incidence of lead based paint hazards. This is the second highest rate of old housing stock in the country. It is estimated that 25% of rental properties in Vermont fall into the category of good condition, 50% would be considered to be in "fair" condition requiring more work and expense and 25% in poor condition.

The Vermont Department of Health has continuously addressed statewide goals to assure that all one and two year old children are screened for exposure to lead. The CLPPP program has identified the need and assessed strategies for targeting metropolitan areas based on evidence from the blood lead surveillance system. CLPPP identified unique cases of children less than 6 years of age that were screened for lead from the years 1994 to 2003. The surveillance system also identified unique cases of children less than 6 years of age testing with an elevated blood lead (EBL) result. The top ten cities are listed in the table below:

TOP CITIES[1] IN VT WITH ELEVATED BLOOD LEAD LEVELS IN CHILDREN AGE 0 - 5

CITY	# OF UNIQUE CASES	# OF TESTS	% WITH EBL'S
RUTLAND	375	2295	16.3
BURLINGTON	304	3456	8.8
BENNINGTON	256	1944	13.2
BRATTLEBORO	203	1336	15.2
BELLOWS FALLS	136	497	27.4
BARRE	126	1294	9.7
SPRINGFIELD	98	917	10.7
ST. JOHNSBURY	87	698	12.5
RANDOLPH	81	473	17.1
ST. ALBANS	80	922	8.7
NEWPORT	75	723	10.4

The extent of the problem in these metropolitan areas can be compared to the statewide percentage of children screened (ages 0 –5) with elevated blood lead levels. The Vermont blood lead surveillance system analysis of the children tested in 2003 shows a continued decline in the percent of EBL; 4.7 % (317/6715). All metropolitan areas listed above well exceeded this by two and three fold.

[1] Minimum of 70 unique cases

The Vermont Department of Health also looked at the location of Local District Office sites to assess the capacity to target resources in these metropolitan areas. In summary the Vermont Department of Health is made up of six divisions. The Vermont CLPPP works out of the division of Health Protection. The division of Community Public Health, which has collaborated from the beginning on lead poisoning prevention activities, is made up of twelve district offices located in the major metropolitan areas of the state; Burlington, Bennington, Brattleboro, Barre, Springfield, St. Albans, St. Johnsbury, Middlebury, Morrisville, Newport, Rutland, and White River Jct. The high-risk town of Bellows Falls and Randolph are served by two of the local District Offices; Springfield and White River Jct.

The Vermont Department of Health also looked at the age of housing stock built before 1978 to identify high-risk metropolitan areas. The areas with the highest number of housing built before 1978 are also the areas where children with the highest number of elevated blood lead levels were identified: Rutland, Burlington, Bennington, Brattleboro, Barre, Springfield/Bellows Falls (a.k.a. Rockingham), St. Johnsbury, and White River Jct. (Hartford). Randolph like all Vermont towns has a high percentage of buildings constructed before 1950 (greater than the national average of 27 %). Subsequently the Vermont Department of Health's White River Jct., District Office will work with the Randolph community under this project period. Although these metropolitan areas will be targeted for primary prevention goals and objectives, the Vermont Lead law will incorporate the entire state for primary prevention because of the old housing in all of Vermont's towns and cities (40.5%).

The Vermont Department of Health also reviewed populations of children age 0-5 living in the towns and cities across the state. The evidence is clear that the location of the children with EBLS is also the location of the state's largest populations. By targeting efforts in these high-risk metropolitan areas, 18% (7602/41,703) of the state's population of children age 0 –5 will be covered. The population for these areas is as follows: Rutland (1,194), Burlington (2,158), Bennington (1,068), Brattleboro (756), Barre (678), Springfield/Bellows Falls (591/378), and St. Johnsbury (467).

To summarize, during this elimination effort the Vermont CLPPP will collaborate with eight District Health Offices that work in the high-risk metropolitan areas and continue to work with the other four District Offices and state partners throughout the state to implement the goals and objectives to eliminate childhood lead poisoning. While the majority of resources and person-power will be targeted to these high risk metropolitan areas, the elimination plan is directing initiatives statewide. This targeted and statewide plan within this application demonstrates the capacity and need to increase Vermont's resources (personnel and time) in order for the Vermont Department of Health to achieve the goals stated in this project period. Vermont Lawmakers made it clear through policy passed in 1993 and 1996 that the elimination of lead poisoning is possible through statewide lead screening plan and lead poisoning prevention law.

III. METHODOLOGY

Facilitated Advisory Committee Meetings

The elimination plan workgroup or advisory committee was convened to assist with the planning, implementation and evaluation process and was a critical aspect of the plan development. Members were asked to participate based on their diversity of knowledge and perspectives as well as their interest and commitment to eliminating lead poisoning in the State of Vermont. Advisory committee members were made up of a diverse range of stakeholders including parents, housing organization advocates, medical providers, realtors, landlords, lawyers and local district office Health Department staff. For the complete list of advisory committee members see Attachment A. It became clear early on that it would be difficult for the group to meet regularly. Many of the advisory committee members were already meeting as smaller groups to address housing and health issues. The committee decided that the most effective approach in moving forward efficiently would be to develop task groups.

Task Forces

Smaller task force groups were set up from the larger advisory group. Housing agencies and environmental testing companies focus on primary prevention and remediation services, also on improvement to Lead Law compliance. Area lawyers and the presidents of the Vermont Property Owner's Associations work towards Lead Law compliance on the Housing Task Force with these agencies and companies. The health care provider task force focuses on issues of insurance reimbursement, improving screening rates, educating parents and other health care providers who aren't currently testing all one and two year olds. They also discuss outreach to the emerging refugee population in Vermont. The day care provider task force, facilitated jointly with the Department of Social and Rehabilitative Services, organizes health education materials for registered day care facility owners, including lead law information. Each group is facilitated by the CLPPP coordinator and has at least one parent advocate as a member.

At this time we have not had a landlord that is willing to participate. CLPPP has structured interviews that are informal to glean useful information from this necessary network of individuals. Topics of conversation to date included, but were not limited to, the Lead Law, costs associated with Lead Law compliance and rental housing code.

VERMONT'S PLAN
TO ELIMINATE CHILDHOOD LEAD POISONING
BY 2011

Overview

This proposal will be broken down by task force group as the majority of plan development and implementation will happen through these three working groups. For a list of individuals responsible for activities, please see attachment A. All activities and goals were developed in accordance with CDC guidelines and through the approval of the CLPPP. Primary prevention efforts will focus on compliance with Vermont's comprehensive Lead Law and housing remediation resources.

A. Health Care Provider Task Force

Goal: 100% of 1 and 2 year old children are tested for lead by 2011.

Measurable Objectives:

- To increase by 20% the number of 1 and 2 year old children screened for lead by December 31, 2006.
- To increase by 25% the percentage of physicians who screen children in their practices by December 31, 2006.
- To increase the percentage of physicians who currently screen some children in their practices to include all children in the practice ages 1 and 2.
- Empower parents to get their children tested for lead.

The CLPPP has put into action a new lead screening advisory committee involving all members of the health care provider task force. VTCLPPP has had such committees in the past, as mentioned in the overview. Based on the previous two years surveillance information, it has become decidedly imperative to change the lead screening recommendation. Currently, health care providers are encouraged to screen all one and two year old children but only screening at two years after asking a series of questions (residing or going to day care in pre-1978 housing, Medicaid, etc.) With only 18% of our two year olds being tested in Vermont and a 5.5% EBL rate, we need to recommend that all two year olds are screened.

The Lead Screening Advisory Committee consists of the Health Care Provider Task Force, the VT Chapter of the American Academy of Pediatrics, local pediatricians and family practitioners, and many divisions of the Department of Health including; Health Surveillance, Health Protection (which houses CLPPP), Community Public Health, and Health Improvement. This committee will work for a few months with the data and

determine the best positioning for getting the message to other health care providers in the state.

Currently, CLPPP is working to empower parents to *tell* their child's pediatrician to screen their children. In 2002, the two year old screening rate was only 12%. The past year has seen quite an improvement. CLPPP recognizes parents for this improvement. Also, the local district offices deserve credit for reaching out to providers in their communities to encourage them to screen all one and two year olds and the health care providers for screening the children.

Data:

2003	**1 year old**	**2 year olds**	**3 year olds**	**4 year olds**	**5 year olds**	**6 year olds**
Number of children tested	4307	1248	424	270	119	48
Estimated population by year	6776	6776	6776	6776	6776	6776
Percent tested	64%	18%	6%	4%	2%	<1%
Lead Level						
10-14 µg/dL	111	51	24	10	2	3
15-19 µg/dL	27	10	5	4	1	0
20+ µg/dL	10	8	2	0	0	0
Total	148	69	31	14	3	3
Percent of Elevated Blood Lead Levels	3.4%	5.5%	7%	5%	<1%	<1%

ACTIVITES/IDEAS:

Provider Outreach through the Health Care Provider Task Force

- Lead Screening Advisory Committee recommendation and information/ recommendation dissemination.
- District offices visit all health care providers in their community to encourage them to screen all of their one and two year old patients. District office staff present data specific to the provider's community including, but not limited to, pre-1978 housing percentage, "hot spots" or areas in the geographic area where there have been many poisoned children, number of children at risk, CDC recommendations, and Vermont Department of Health recommendations.

- Pediatric and Family Practice Grand Rounds presented to provider community by the Commissioner of Health, Paul Jarris. New screening recommendations presented at this time as well as housing information, etc.
- Work with VT insurance providers to do a direct mailing to primary care providers in the state detailing reimbursement policies.
- Health Care Provider Task Force will work with insurance providers to ascertain whether or not insurance reimbursement can be improved.
- CLPPP will match children enrolled in Medicaid with the VT Lead Surveillance database to identify one and two year old children not be screened in the targeted areas. This information will then be presented to area physician practices.
- Work closely with the OB/Midwife community to disseminate information. Actively seek out OB/Midwives as participants in the Lead Screening Advisory Committee.
- Education through VNA visits with pregnant women and families with children less than 1 year of age that are enrolled in the Healthy Babies, Kids, and Families program are one activity. Tracking the outcomes of subsequent blood lead testing of these children, as they turn one, is one method of using the surveillance system to evaluate impact.

Vermont Department of Health activities

- Screen one and two year old children attending health clinics through WIC who are not already being screened by their provider to assure that all one and two year olds on WIC are screened.
- Maintain quality control and accuracy of CLPPP database.
- Work with Dartmouth college PhD. students on a geocoding project matching EBLs with housing stock and zip code. This information will be used to present to physicians.
- Postcard sent to all parents/guardians of 10 and 22 month old children reminding them that their child needs a lead test at ages one and two.
- Lead education in prenatal classes and newborn visiting programs.
- When sending lead test results to parents, include information in the letter that is educational for parents to help them to lower their child's EBL as quickly as possible.
- Work with Dr. First (*First on Kids* television program on local news station) to run a lead prevention series.
- Develop partnership with statewide Parent and Child Centers.
- Work with the refugee resettlement programs in the state to target the immigrant/new American population. Develop a partnership with area physicians to have the refugees retested for lead 2 months after entry into the United States, as well as upon initial entry.

- Development of lead outreach tool/strategy disseminated through hospital well-baby kits.
- Information disseminated through OB/GYN offices throughout the state.
- Case management through CLPPP.
    - Parents of children with EBLs of 10-14 µg/dL will be called for phone counseling and mailed information.
    - Parents of children with EBLs of 15-19 µg/dL will be visited at their homes where minor environmental testing will be completed and they will receive educational information.
    - Parents of children with EBLs of 20+ µg/dL will be visited at their homes where a full environmental investigation will be completed, they will receive lead education and will be referred to the Family, Infant, Toddler program for nutritional and developmental assessments.

EVALUATION PLAN:

Evaluation of the aforementioned goals and objectives will be the responsibility of the CLPPP Lead Surveillance Specialist. Data obtained will be blood lead levels, number of children tested, and querying EBL distribution. All activities will be tied to this system for evaluation.

B. Housing Task Force

Goal 1: Full compliance with Lead Law Regulations by December 31, 2011.

Measurable Objectives:

- To ensure that Town Health Officers understand the lead law and have the information they need to carry out their duties by December 31, 2006.
- Restructure EMP class and manual by January 2005.
- Organize Lead Law review committee by December 31, 2005.
- To receive 3,584 affidavits in 2005 and an increase of 10% of affidavits each subsequent year of the project period.
- Create a rental database by December 31, 2006.

ACTIVITES/IDEAS:

Town Health Officers (THO) outreach through CLPPP

- Essential Maintenance Practices complaints come through the THOs; therefore it's imperative that they are well versed in the lead law. CLPPP will organize information for this network of individuals so that they can do their jobs more effectively and continue to protect public health.
- CLPPP will restructure the THO training and complete another "train-the-trainer" informational session for Environmental VDH District Offices Designees.

- A protocol manual will be developed by CLPPP for THOs so that there is no question for them when they go to a complaint what actions they should take.

Rental Property Owners outreach through the Housing Task Force

- The EMP class will be revised by CLPPP, VHCB and BLP - both the class structure and the manual will be revised. CLPPP wants the manual to be a resource tool for class participants to reference after they've taken the course. A "train-the-trainer" class will update current trainers of the changes.
- Increase the number of EMP classes being offered in areas where there is a greater percentage of EBLs. Train local property owners and housing officials to instruct the course.
- A rental property owner database will be created to help CLPPP to monitor the affidavit process and compliance. Currently, no such list exists so CLPPP doesn't even know the addresses of all rental property owners. Once the list is created, targeted marketing to this group will be the aim of the collaborative of the Housing Task Force. Property owners will be educated on the lead law and will be inspected for compliance. There will be follow up by CLPPP to those landlords that do not submit their annual affidavit. Currently the compliance with the lead law is low and this needs to be improved. In 2003, CLPPP received 2,555 Affidavits of Essential Maintenance Practices and there are 70,000 rental properties in the state.

Housing Task Force

- Identify construction projects and work towards improved permitting of lead based projects.
- Identify requirements of each town for zoning. Work with zoning office to improve education and compliance around lead remediation projects.
- Work with banks to distribute lead safe renovation information to individuals who are getting loans to remodel their homes.
- Work with first time home buyer programs to provide lead education.
- Explore lower insurance costs or rebates on insurance premiums for property owners who delead and comply with the law.
- Explore working with towns and cities to include affidavit and/or LBP information in tax, water, sewer, etc. in bills and mailings.

Vermont Department of Health Services

- Develop marketing materials for hardware stores to improve their understanding of the increase number of materials they can sell when their customers work lead safe. Therefore, they will actively talk with their customers about lead dangers and the lead law.

- Work with legal council at the Health Department to issue health orders in the rental property homes of poisoned children.
- Work with legal council at the Health Department to bring suits against multiple offender landlords.
- EPA Lead and Asbestos Regulatory Program to promote enforcement of 406 Pre-Renovation Education Notification.
- Recognize property owners' compliance with the law through awards, incentives for compliant property owners.

Goal 2: Public education concerning lead hazards through December 31, 2011.

ACTIVITIES/IDEAS:

- Develop a media campaign with VHCB and the Burlington Lead Program (BLP). Marketing materials will be sent to every residence in the state detailing the importance of compliance with the lead law. BLP will pay for the mailing to every Burlington zip code, VHCB for the development of the media materials by a marketing firm and CLPPP will pay for the mailing to the rest of the state.
- Collaborate with the University of Vermont to develop GIS maps to identify high-risk neighborhoods and then target resources and education.
- Develop community grant program in which community coalitions advocate and provide awareness and education.

EVALUATION:

- CLPPP will continue to develop the affidavit database. This will be completed by November 15, 2004. CLPPP will be able to query data including location of properties, number of affidavits received, multiple property landowners, and compliance by year. Reports will be generated on the success of efforts to improve EMP affidavit compliance and distributed to Elimination Plan larger group.
- GIS maps created by UVM will help to identify EBLs, multiple offender property owners, and "hot spots".
- Lead Surveillance system
- Focus group testing on all marketing/media materials
- Number of EMP complaints handled successfully by THOs
- Number of landlords reached by marketing/media materials including inserts in tax and property services bills, paychecks, etc.
- Quarterly and annual reports submitted by community coalition coordinators.

C. Day Care Provider Task Force

Goal: To provide training to all day care licensors in the State and assure they are complying with the Lead Law

Measurable Objectives:

- **Assure that all day care licensors receive training in the EMP requirements for day care providers by December 31, 2006.**
- **To receive the total number of day care affidavits as there are registered day care facilities by December 31, 2007**

ACTIVITIES/IDEAS:

- CLPPP to provide trainings to day care licensors at different locations throughout the state. Work with the Childcare Licensing Division to assure that all licensors are required to attend.
- Work with Childcare Licensing Division to send a mailing to all registered day care facility owners detailing for them their responsibility under the lead law to complete EMPs and send in a yearly affidavit.
- Childcare Licensing Division will become qualified to do compliance checks of the registered day care properties to assure compliance with EMPs.

EVALUATION:

- CLPPP will continue to develop the affidavit database. This will be completed by November 15, 2004. CLPPP will be able to query data including location of day care facilities, number of affidavits received, and compliance by year. Reports will be generated on the success of efforts to improve EMP affidavit compliance and distributed to Elimination Plan larger group and Childcare Licensing Division.
- Number of registered day care facility owners that attend the VTCLPPP trainings locally.

Surveillance and Evaluation

Overview

Surveillance data is critical to the day-to-day program operations, for prioritizing and directing resources, evaluating program effectiveness, and developing policy. The foundation of Vermont's statewide surveillance system is the collection of all blood test results that are transferred electronically (95%) and completely as outlined by state regulation. This database is child and adult specific and includes demographic information as well as information on residence, health care provider, and insurance. Unique identifiers exist both for children and for addresses, and quality assurance includes data entry and import edit checks.

VTCLPPP staff use the statewide surveillance database to perform trend analyses for all Vermont communities and generate reports on the prevalence and incidence of blood lead levels. These reports are disseminated annually to health care providers, high-risk communities, the Vermont legislature, and other interested parties. VTCLPPP also submits data to CDC annually and on a quarterly.

Evaluation will be conducted primarily by CLPPP through the lead surveillance system and the affidavit database. Housing reports will be developed by the VHCB and the BLP including figures on housing remediation. The insurers, including Medicaid, will match enrolled individuals with the lead surveillance system to determine rate of testing within the population.

For marketing and outreach materials, CLPPP will conduct focus group testing to assure the appropriateness of the messaging. The number of individuals reached by the marketing materials will be tracked as well as calls to the 1-800 lead hotline associated with the mailings.

Evaluation data will be presented to the Elimination Plan Workgroup on an annual basis in March as well as to the Vermont state legislature, Commissioner of Health, and other project partners. CDC will receive this information by way of annual reports submitted according to CDC guidance documentation. After review of the evaluation outcomes, workgroup members, CDC and CLPPP will develop ways to improve progress towards elimination. An annual meeting with workgroup participants will address this issue specifically. Work plan updates and any changes will be approved through CDC and monitored closely through the aforementioned database resources.